

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02166

2171 CERTIFICATE OF DEATH

Reg. Dist. No. 290

| | | | | | | | |
|---|-------------------|--|---------------------|---|------------------------|--|------------|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>Talbot</u> | | MARYLAND | | STATE <u>md.</u> | | COUNTY <u>Cecil</u> | |
| CITY (If outside corporate limits, write RURAL or and give nearest town) | | LENGTH OF STAY (In this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN | | | |
| 40 TOWN <u>Easton, Md.</u> | | 16 days | | Federalsburg 051-2 | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural, give location) | | | |
| 80 <u>Easton Memorial Hospital</u> | | | | | | | |
| 3. NAME OF DECEASED: (First) (Middle) (Last) | | | | 4. DATE (Month) (Day) (Year) OF DEATH: | | | |
| <u>Albert C. Andrew</u> | | | | <u>2 15 1956</u> | | | |
| 5. SEX: | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): | 8. DATE OF BIRTH: | 9. AGE last birthday yrs. | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. Days | Hours Min. |
| <u>Male</u> | <u>white</u> | <u>MARRIED</u> | <u>May 19, 1884</u> | <u>71</u> | | | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): | | | | 10B. KIND OF BUSINESS OR INDUSTRY: | | 11. BIRTHPLACE (State or foreign country): | |
| <u>Carpenter</u> | | | | <u>Carpenter</u> | | <u>Maryland</u> | |
| 13. FATHER'S NAME: | | | | 14. MOTHER'S MAIDEN NAME: | | | |
| <u>Martin Luther Andrew</u> | | | | <u>Martha Adams</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. (If Yes, give year or dates of service) | | 17. INFORMANT & ADDRESS: | | | |
| <u>no</u> | | <u>218-05-2554</u> | | <u>Mrs. Carrie M. Andrew (wife)</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 332X IMMEDIATE CAUSE (A) <u>Cerebral aneurysm</u> | | | | | | | |
| ANTECEDENT CAUSE (S) DUE TO (B) <u>Cerebral thrombosis</u> | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19A. DATE OF OPERATION: | | 19B. MAJOR FINDINGS OF OPERATION | | | | | |
| <u>2</u> | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, street, office bldg., etc.) | | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from <u>1/31</u> , 19 <u>56</u> , to <u>2/15</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2/15</u> , 19 <u>56</u> , and that death occurred at <u>2:50</u> P. M. from the causes and on the date stated above. | | | | | | | |
| SIGNATURE | | M. D. | | ADDRESS | | DATE SIGNED | |
| <u>Edw. H. Nevers</u> | | <u>Captain</u> | | <u>Federalsburg Md R1</u> | | <u>17 Feb 1956</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>2/18/56</u> | | <u>Bethel</u> | | <u>Federalsburg Md R1</u> | |
| DATE REC'D BY LOCAL REGISTRAR | | REGISTRAR'S SIGNATURE | | 24. FUNERAL DIRECTOR | | ADDRESS | |
| <u>2/16/56</u> | | <u>N. H. Nevers</u> | | <u>Harvey Williams</u> | | <u>Federalsburg Md.</u> | |

BUREAU V. S.

FEB 23 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that a death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2186 CERTIFICATE OF DEATH

02167

Reg. Dist. No. 290

| | | | | | | | |
|--|------------------|--|------------------|---|---|---|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>Talbot</u> | | MARYLAND | | STATE <u>Maryland</u> COUNTY <u>Talbot</u> | | | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (In this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN <u>Easton</u> | | <u>Life</u> | | TOWN <u>Easton</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Route 2</u> | | | | STREET ADDRESS (If rural give location) <u>Route 2</u> | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) <u>Katie</u> (Middle) <u>S.</u> (Last) <u>Blake</u> | | | | (Month) <u>2</u> (Day) <u>21</u> (Year) <u>1956</u> | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | 10. IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.) | | |
| <u>Female</u> | <u>Col</u> | <u>married</u> | <u>5/13/06</u> | <u>49</u> yrs. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | |
| <u>Factory labor Domestic</u> | | | | <u>Maryland</u> | | <u>U.S. A</u> | |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| <u>John H. Skinner</u> | | | | <u>Sarah Williams</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | |
| | | | | <u>29-14-3658</u> | | <u>Zeemon Blake Canton, Md</u> | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 10. MEDICAL CERTIFICATION | | | |
| 331X IMMEDIATE CAUSE (A) | | | | <u>Cerebral hemorrhage</u> | | | |
| ANTECEDENT CAUSE(S) DUE TO | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO | | | | | | | |
| STATING UNDERLYING CAUSE LAST. (C) | | | | | | | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at..... M., from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Louis O'Malley DME M.D.</u> | | | | ADDRESS (Street, city, town, state) <u>Easton Md</u> | | DATE SIGNED <u>2-25-56</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>2/26/56</u> | | <u>New Chapel Cem.</u> | | <u>Easton Rt 2 MD.</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| <u>2/23/56</u> | | <u>N.H. Nevein</u> | | <u>James S. Daniel</u> | | <u>Easton Md</u> | |

CERTIFICATE OF DEATH

BUREAU V. S.

MAR 5 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and coroner must be filled in by the funeral director, TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and coroner, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2187

CERTIFICATE OF DEATH

02168

Reg. Dist. No.

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lumis Mills (Rural)</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lumis Mills (Rural)</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>00</u> | | d. STREET ADDRESS <u>1</u> | |
| 3. NAME OF DECEASED (Type or print) <u>John</u> First <u>Flamer</u> Middle <u>Flamer</u> Last | | 4. DATE OF DEATH <u>Feb</u> Month <u>27</u> Day <u>1956</u> Year | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Caucas.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>June 2, 1909</u> |
| 9. AGE (In years last birthday) <u>86</u> yrs. | | IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Talbot</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farm Hand</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Alexander Flamer</u> | | 14. MOTHER'S MAIDEN NAME <u>Charlotte Roberts</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u> | | 16. SOCIAL SECURITY NO. <u> </u> | |
| 17. INFORMANT <u>Mary Ethel Mooney</u> Address <u>Lumis Mills</u> | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Left Hemiplegia</u> 334X DUE TO <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>yes</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u> | 20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>Feb 22</u> , 19 <u>56</u> , to <u>Feb 27</u> , 19 <u>56</u> ; that I last saw the deceased alive on <u>Feb 26</u> , 19 <u>56</u> , and that death occurred at <u>6 P.</u> M., from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>M. F. Buell</u> | | ADDRESS (Street, city or town, state) <u>19 Goldboro St. Easton, Md.</u> DATE SIGNED <u>3-1-56</u> | |
| PHYSICIAN'S NAME (Type) <u> </u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>Mar. 2, 1956</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Coppersville Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>Lumis Mills Talbot Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>M. E. Swannerton</u> ADDRESS <u>Easton</u> | | 24a. REC'D BY REGISTRAR <u> </u> DATE <u>3/2/56</u> | 24b. REGISTRAR'S SIGNATURE <u> </u> |

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

BUREAU V. S.

MAR 6 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2188 CERTIFICATE OF DEATH

02169

Reg. Dist. No.

| | | | |
|--|--------------------------------|--|------------------------------------|
| 1. PLACE OF DEATH COUNTY <u>talbot</u> MARYLAND CITY (If outside corporate limits, write RURAL or give nearest town) <u>Easton</u> TOWN <u>Easton</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Route II</u> | | 2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>talbot</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> OR TOWN <u>Easton</u> STREET ADDRESS (If rural give location) <u>Route II</u> | |
| 3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Sadie E. Flamer</u> | | 4. DATE OF DEATH (Month) (Day) (Year) <u>2 14 19 56</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Col</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u> | 8. DATE OF BIRTH <u>2/10/72</u> |
| 9. AGE last birthday <u>84</u> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Gustavus Smith</u> | | 14. MOTHER'S MAIDEN NAME <u>Rachel Ann Tilghman</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>See Easton, Md.</u> | |
| 17. INFORMANT & ADDRESS <u>See Easton, Md.</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 430.1 IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized Arterio Sclerosis</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Diabetes Mellitus</u> | | 15. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>yes</u> <u>yes</u> | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | |
| 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) (Second) (M) (P) (A) (N) | |
| 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from <u>1-1-1956</u> , to <u>2-14-1956</u> , that I last saw the deceased alive on <u>2-13-1956</u> , and that death occurred at <u>5:00</u> A.M. from the causes and on the date stated above. | | | |
| SIGNATURE <u>W. F. Buell</u> | | DATE SIGNED <u>2-18-56</u> | |
| ADDRESS (Street, city, town, state) <u>Easton, Md.</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>2/18/56</u> | |
| NAME OF CEMETERY OR CREMATORY <u>Chappel Cem.</u> | | LOCATION (City, town, or county) (State) <u>Easton Rt 2, MD</u> | |
| 24. REC'D BY REGISTRAR <u>FB 27 1956</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Darrell</u> | |
| REGISTRAR'S SIGNATURE <u>N. J. Harris</u> | | ADDRESS <u>Easton, Md.</u> | |

STATE CERTIFICATE OF DEATH

BUREAU V. S.

EB 27 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by filling in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02170

2189

CERTIFICATE OF DEATH

Reg. Dist. No. 290

| | | | |
|---|-------------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Talbot MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Talbot | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Trappe | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Trappe | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 20 | | d. STREET ADDRESS X | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Katie Middle M. Last Frampton | | 4. DATE OF DEATH Month Feb. Day 23 Year 19 56 | |
| 5. SEX Female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Oct. 22, 1875 |
| 9. AGE (In years last birthday) 80 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Md. | |
| 11. BIRTHPLACE (State or foreign country) U. S. | | 12. CITIZEN OF WHAT COUNTRY? U. S. | |
| 13. FATHER'S NAME Silas Sullivan | | 14. MOTHER'S MAIDEN NAME Mary E. Helsby | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. none | |
| 17. INFORMANT Bennett Frampton | | Address Trappe, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Hepatitis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Generalized arteriosclerosis - | | INTERVAL BETWEEN ONSET AND DEATH 2 weeks - | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none | |
| 20c. TIME OF INJURY Month, Day, Year Hour none p. m. none | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Jan 2-23 - 1956 to Jan 2-23, 1956 that I last saw the deceased alive on Jan 2-23 - 1956 and that death occurred on Jan 2-23 - 1956 at 9:30 A.M. from the causes and on the date stated above. | | ADDRESS (Street, city or town, state) DATE SIGNED 2-26-56 | |
| ACTUAL SIGNATURE William L. Winters M.D. | | | |
| PHYSICIAN'S NAME (Type) WILLIAM L. WINTERS | | EASTON MARYLAND | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) burial | 22b. DATE THEREOF 2-27-56 | 22c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery | |
| 22d. LOCATION (City, town, or county) (State) Easton, Talbot, Maryland | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W. E. Newman | | 24a. REC'D BY REGISTRAR 2/24/56 | |
| ADDRESS Easton Md. | | 24b. REGISTRAR'S SIGNATURE W. E. Neekes | |

RECEIVED

MAR 5 1956

BUREAU V. S.

CERTIFICATE OF DEATH

INVESTIGATION OF DEATH - BUREAU OF HEALTH - BUREAU OF VITAL STATISTICS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9, Film 3-11-56 et

2172

CERTIFICATE OF DEATH

Reg. Dist. No.

03272

290

| | | | |
|---|-------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Talbot</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> c. LENGTH OF STAY IN IT <u>5 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Michaels</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>Engel</u> Last <u>Engel</u> | | 4. DATE OF DEATH Month <u>Feb.</u> Day <u>24</u> Year <u>1956</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug. 20, 1896</u> |
| 9. AGE (In years last birthday) <u>59</u> | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>5</u> Days <u>16</u> Hours <u>01</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>MD.</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>MD.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Fred Engel</u> | | 14. MOTHER'S MAIDEN NAME <u>Minnie Moskey</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes World War I</u> | | 16. SOCIAL SECURITY NO. <u>Edward Wrothen - St Michaels MD.</u> | |
| 17. INFORMANT <u>Edward Wrothen - St Michaels MD.</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Left thrombosis</u> DUE TO (b) <u>cerebral hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>6 days</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>2-19</u> , 19 <u>56</u> , to <u>2-24</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2-23</u> , 19 <u>56</u> , and that death occurred at <u>1:40</u> A.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Dr. F. B. Buehl</u> | | ADDRESS (Street, city or town, state) <u>St Michaels, Talbot Co, MD.</u> | |
| PHYSICIAN'S NAME (Type) <u>Dr. F. B. Buehl</u> | | DATE SIGNED <u>2-27-56</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Feb. 27, 1956</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Calvert Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>St Michaels, Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>St. Ambrose Harrison, St Michaels, Md</u> | | ADDRESS | |
| 24a. REC'D BY REGISTRAR <u>2/27/56</u> | | 24b. REGISTRAR'S SIGNATURE <u>M. H. Neuman</u> | |

BUREAU A. S.

Nov 6 1900

RECEIVED

Item 7, Filed 1952 2-20-56 et

CERTIFICATE OF DEATH

Reg. Dist. No. 290...

1. PLACE OF DEATH:

COUNTY

Tolboi

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town)
OR
TOWN EastonLENGTH OF STAY
(in this place)

1 mo - 12 days

HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md

COUNTY

Queen Anne

CITY (If outside corporate limits, write RURAL and give nearest town)
OR
TOWN Queen Anne - Box 253STREET
ADDRESS

(If rural give location)

3. NAME OF
DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

Mary

Helen

Godwin

4. DATE (Month)

(Day)

(Year)

OF
DEATH: Feb

10

1956

5. SEX:

F

6. COLOR OR
RACE:

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify): Widowed

8. DATE OF BIRTH:

Dec. 8, 1898

9. AGE last birthday

77

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life,
even if retired):

none

10B. KIND OF BUSINESS
OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

Penna

12. CITIZEN OF WHAT
COUNTRY?

USA

13. FATHER'S NAME:

Jefferson Gray

14. MOTHER'S MAIDEN NAME:

Sarah Beecher

15. WAS DECEASED EVER IN U.S. ARMED FORCES
(Yes, no, or unk.) (If Yes, give war or dates
of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS:

Mrs Betty Taylor (friend)

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE

(A)

DUE TO

Cardiac failure

INTERVAL BETWEEN
ONSET AND DEATH

5 wks

ANTECEDENT CAUSE (S)

(B)

DUE TO

Myocardial infarction

5 wks

DISEASES OR CONDITIONS, IF ANY,
GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST.

(C)

Coronary atherosclerosis

(?)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21B. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)21C. WHERE DID (City or town)
INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

21E. INJURY OCCURRED

While ☐ Not while ☐
at work at work

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 29th Dec., 1955, to 10th Feb., 1956, that I last saw the deceased alive on 10th Feb., 1956, and that death occurred at 9:25 P.M. from the causes and on the date stated above.

SIGNATURE

M. D. M. D. M. D.

ADDRESS

Easton Maryland

DATE SIGNED

11 Feb 56

23. BURIAL, CREMATION,
REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town or county)

(State)

DATE REC'D BY LOCAL
REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

8/11/56

M. D. M. D. M. D.

Edward J. Bellows Millington Md

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 11 1964

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02172

2174 CERTIFICATE OF DEATH

Reg. Dist. No. 290...

| | | | | | | | |
|--|----------------------------|--|---------------------------------------|--|------------------------------|--|-----------------------------|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>TALBOT</u> | | MARYLAND | | STATE <u>MARYLAND</u> COUNTY <u>TALBOT</u> | | | |
| CITY (If outside corporate limits, write RURAL or and give nearest town) <u>Easton</u> | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>RURAL - LAAGWOODS</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>"WYE HEIGHTS"</u> | | | | STREET ADDRESS (If rural give location) | | | |
| 3. NAME OF DECEASED: (First) <u>WALTER</u> (Middle) <u>CHARLES-VINSON</u> (Last) <u>GRUBB</u> | | | | 4. DATE (Month) (Day) (Year) OF DEATH: <u>2</u> <u>3</u> <u>1956</u> | | | |
| 5. SEX: <u>M</u> | 6. COLOR OR RACE: <u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u> | 8. DATE OF BIRTH: <u>MAY 23, 1905</u> | 9. AGE last birthday <u>50</u> yrs. | IF UNDER 1 YEAR: Months Days | | IF UNDER 24 HRS: Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>LABORER</u> | | 10B. KIND OF BUSINESS OR INDUSTRY: <u>FARMING</u> | | 11. BIRTHPLACE (State or foreign country): <u>PENNA.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME: <u>FRANK GRUBB</u> | | | | 14. MOTHER'S MAIDEN NAME: <u>ELIZABETH SWEENT</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service) <u>NONE</u> | | 16. SOCIAL SECURITY No. <u>218-16-7149</u> | | 17. INFORMANT & ADDRESS: <u>KATHARINE M. GRUBB, EASTON, R.D., MD</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| IMMEDIATE CAUSE | | (A) <u>Coronary Occlusion c Myocardial Infarction</u> | | DUE TO | | <u>Hours?</u> | |
| ANTECEDENT CAUSE (S) | | (B) | | DUE TO | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. | | (C) | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19A. DATE OF OPERATION: | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? | | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>2-3-1956</u> , 19 <u>56</u> , to <u>7:50 P.M.</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2-3-1956</u> , and that death occurred at <u>7:50 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Donald H. Barkley</u> | | ADDRESS <u>Easton, Md.</u> | | DATE SIGNED <u>2-3-56</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u> | | DATE THEREOF <u>FEB. 7, 1956</u> | | NAME OF CEMETERY OR CREMATORY <u>LANDING NECK CEMETERY</u> | | LOCATION (City, town, or county) (State) <u>EASTON, R.D., MARYLAND</u> | |
| DATE REC'D BY LOCAL REGISTRAR <u>2/4/56</u> | | REGISTRAR'S SIGNATURE <u>N.A. Newvine</u> | | 24. FUNERAL DIRECTOR <u>W. Hampton Canell</u> | | ADDRESS <u>EASTON, MD.</u> | |

RECEIVED

FEB

1967

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2175

CERTIFICATE OF DEATH

Reg. Dist. No.

02173

290

| | | | |
|---|---------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sherwood</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u> | | d. STREET ADDRESS <u>?</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Lucy V. Landon</u> | | 4. DATE OF DEATH <u>Feb. 21 1956</u> | |
| 5. SEX <u>Fe</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 1, 1896</u> |
| 9. AGE (In years last birthday) <u>57</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>John T. Landon</u> | | 14. MOTHER'S MAIDEN NAME <u>Margie Parks</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 17. INFORMANT <u>Mr. J. Herman Landon (brother)</u> Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive cerebral vascular</u> DUE TO (c) <u>cardiac failure - acute</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>42 hrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Aug 1953</u> to <u>2-21 1956</u> , that I last saw the deceased alive on <u>2-21 1956</u> , and that death occurred at <u>11:45 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>St Michael md</u> DATE SIGNED <u>2-24-56</u> | | | |
| ACTUAL SIGNATURE <u>Thy M. Reeser Jr</u> M.D. | | PHYSICIAN'S NAME (Type) <u>Thy M. Reeser Jr</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY | 22d. LOCATION (City, town, or county) (State) |
| <u>Burial</u> | <u>2/23/56</u> | <u>Sherwood</u> | <u>Sherwood Md</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Norman D. Marshall - St. Michael</u> ADDRESS | | 24a. REC'D BY REGISTRAR <u>2/22/56</u> 24b. REGISTRAR'S SIGNATURE <u>N. H. Reeser</u> | |

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAR 5 1

BUREAU V. S.

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02174

2190

CERTIFICATE OF DEATH

Item 9, Film 0194 3-23-56 et

Reg. Dist. No. 290

| | | | | | | | |
|--|-----------------------------|---|----------------------------------|---|--|---|-----------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY Talbot | | STATE Maryland COUNTY Talbot | | CITY (If outside corporate limits, write RURAL and give nearest town) Easton | | CITY (If outside corporate limits, write RURAL and give nearest town) Easton | |
| CITY (If outside corporate limits, write RURAL and give nearest town) Easton | | LENGTH OF STAY (in this place) life | | TOWN Easton | | TOWN Easton | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS Route 2 | | | | STREET ADDRESS (If rural give location) Route II | | | |
| 3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) George R. Little | | | | 4. DATE OF DEATH (Month) (Day) (Year) 2 28 19 56 | | | |
| 5. SEX Male | 6. COLOR OR RACE Col | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single | 8. DATE OF BIRTH 10/17/41 | 9. AGE last birthday 13 14 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) student | | 10b. KIND OF BUSINESS OR INDUSTRY student | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME James Little | | | | 14. MOTHER'S MAIDEN NAME Viola Brooks | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) — | | 16. SOCIAL SECURITY NO. — | | 17. INFORMANT & ADDRESS Mr. James Little, Easton, Md. | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| IMMEDIATE CAUSE (A) Broken neck | | | | INTERVAL BETWEEN ONSET AND DEATH — | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) — | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) — | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. — | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input checked="" type="checkbox"/> | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) farm | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) Talbot Maryland | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 3:30 Feb 28 1956 P.M. | | 21e. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? Tractor rolled over on him | | | |
| 22. I hereby certify that I attended the deceased from 28 Feb , 19 56 to — , 19 — , that I last saw the deceased alive on — , 19 — , and that death occurred at — M., from the causes and on the date stated above. | | | | | | | |
| SIGNATURE James B. Dashiell M.D. | | | | ADDRESS (Street, city, town, state) Easton, Md. DATE SIGNED 3/2/56 | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | DATE THEREOF 3/2/56 | | NAME OF CEMETERY OR CREMATORY Williamson | | LOCATION (City, town, or county) (State) Easton Md. | |
| 24. REC'D BY REGISTRAR 3/2/56 | | REGISTRAR'S SIGNATURE N.A. Neeress | | 25. FUNERAL DIRECTOR'S SIGNATURE James B. Dashiell | | ADDRESS Easton, Md. | |

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate should be detached for use as a burial transit permit.

VS 15C 1-55 10M

87A 2

1940

11/11/40
11/11/40

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8, Fil 2176-15 et

2176

CERTIFICATE OF DEATH

Reg. Dist. No.

02175
210

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Talbot MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Talbot | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Creamery Lane | | | | d. STREET ADDRESS Creamery Lane | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Cora Middle D. Marshall Last | | | | 4. DATE OF DEATH Month Feb. Day 22 Year 1956 | | | |
| 5. SEX Female | | 6. COLOR OR RACE white | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH DEC. 26, 1872 | |
| 9. AGE (In years last birthday) 83 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY Dorchester Co. | | 12. CITIZEN OF WHAT COUNTRY? U. S. | |
| 13. FATHER'S NAME WILLIAM SHORT | | | | 14. MOTHER'S MAIDEN NAME MARY MOANEY | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. 219-34-3869 | | | |
| | | | | 17. INFORMANT MR. BERNARD MARSHALL - EASTON MD. Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiac Hypertrophy DUE TO (c) Ca of Thyroid | | | | | | | INTERVAL BETWEEN ONSET AND DEATH Chro yes yes |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) generalized arteriosclerosis | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from 1-1-1956 , to 2-22-1956 , that I last saw the deceased alive on 2-22-1956 , and that death occurred at 3 P. M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Martin F. Buell | | | | ADDRESS (Street, city or town, state) 14 Goldsborough St. Easton, Md. 21828 | | | |
| PHYSICIAN'S NAME (Type) Martin F. Buell | | | | DATE SIGNED 2/23/56 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 2-25-56 | | 22c. NAME OF CEMETERY OR CREMATORY EAST NEW MARKET | | 22d. LOCATION (City, town, or county) (State) EAST NEW MKT. Dorchester MARYLAND | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Marion Newman ADDRESS Easton Md | | | | 24a. REC'D BY REGISTRAR 2/23/56 | | 24b. REGISTRAR'S SIGNATURE M. F. Newman | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 1/2 1/2 1/2

95 1 2

10 1/2 1/2 1/2

2177

CERTIFICATE OF DEATH

02176

Reg. Dist. No. 290

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u> | | d. STREET ADDRESS <u>512 August Street</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Alice</u> Middle <u>E</u> Last <u>Mayer</u> | | 4. DATE OF DEATH Month <u>Feb.</u> Day <u>27</u> Year <u>1956</u> | |
| 5. SEX <u>Fe</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 1, 1888</u> 67 yrs |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>William E. Cairnes</u> | | 14. MOTHER'S MAIDEN NAME <u>Margaret Dulin</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>Mr. William E. Mayer, Son</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct, Recent & Old.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary occlusion</u> DUE TO (c) <u>Atherosclerosis.</u> | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>SEPT.</u> , 19 <u>55</u> , to <u>FEB. 27</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>FEB. 27</u> , 19 <u>56</u> , and that death occurred at <u>8:00</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Donald F. Bartley</u> M.D. | | ADDRESS (Street, city or town, state) <u>9 N. Hanson St. Easton, Md.</u> DATE SIGNED <u>2-27-56</u> | |
| PHYSICIAN'S NAME (Type) <u>DONALD F. BARTLEY</u> M.D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF <u>Feb 27</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>Easton Talbot Md</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>W. E. Newman & Son</u> | | ADDRESS <u>Easton Md</u> | 24b. REC'D BY REGISTRAR <u>2/29/56</u> 24c. REGISTRAR'S SIGNATURE <u>N. H. Newman</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. After the certificate has been signed by the attending physician and completed, it should be filed in by the funeral director. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, it should be filed in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUNNELL & S

1908

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | | 03286 | | |
|--|--|--|---|---|---|---|--|--|--|---|--|--|
| 2191 MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | Reg. Dist. No. 291 | | |
| 1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE PENNSYLVANIA b. COUNTY | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) outside St. Michaels | | | | | c. LENGTH OF STAY IN 1b | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WARREN | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 08 | | | | | d. STREET ADDRESS | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) | | | First Louis Middle Charles Last Niederlander Jr. | | | 4. DATE OF DEATH Month Feb. Day 21 Year 1956 | | | | | | |
| 5. SEX male | | 6. COLOR OR RACE white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 12-12-30 | | 9. AGE (In years last birthday) 25 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) pilot | | | | 10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy | | 11. BIRTHPLACE (State or foreign country) Cleveland Ohio | | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME Louis Charles Niederlander | | | | | 14. MOTHER'S MAIDEN NAME Ione Folkman | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Jet Airplane Crash DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) plane crashed in creek | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 12 p. m. 2-21 19 56 | | | | 20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Bread Ck | | 20f. (City or town) near St. Michaels Talbot | | (County) (State) | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | | | | | | |
| ACTUAL SIGNATURE Louis S. Welty | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | DATE SIGNED 12-21-56 | | | | |
| EXAMINER'S NAME (Type) Louis S. Welty, M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) removal | | 22b. DATE THEREOF 2-21&22-56 | | 22c. NAME OF CEMETERY OR CREMATORY to Naval Air Sta. Chincoteague, Va. | | | | 22d. LOCATION (City, town, or county) (State) | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Templeton Funeral Home, Warren, Pa. | | | | | | 24a. REC'D BY REGISTRAR DATE 3/2/56 | | 24b. REGISTRAR'S SIGNATURE | | | | |



2178 CERTIFICATE OF DEATH

Reg. Dist. No. 290...

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH: | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | |
| COUNTY <i>Talbot</i> | MARYLAND | STATE <i>Maryland</i> | COUNTY <i>Talbot</i> |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Easton, Maryland</i> | LENGTH OF STAY (in this place) <i>23 hrs.</i> | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Easton -</i> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Memorial Hospital - Easton</i> | | STREET ADDRESS (If rural give location) <i>Glenwood Ave.</i> | |
| 3. NAME OF DECEASED: | | 4. DATE (Month) (Day) (Year) | |
| (First) <i>Clara</i> | (Middle) | (Last) <i>Rose</i> | OF DEATH: <i>2 15 1956</i> |
| 5. SEX: <i>Female</i> | 6. COLOR OR RACE: <i>Black</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>H.W.</i> | 8. DATE OF BIRTH: <i>May 3, 1890</i> |
| 9. AGE last birthday: <i>65</i> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>House work</i> | 11. BIRTHPLACE (State or foreign country): <i>Delaware</i> |
| 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 13. FATHER'S NAME: <i>William A. Cannon</i> | |
| 14. MOTHER'S MAIDEN NAME: <i>Sara Horner</i> | | 15. INFORMANT & ADDRESS: <i>Avis E. Johnson (Daughter)</i> | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | 17. SOCIAL SECURITY NO. | |
| 18. MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | |
| (A) IMMEDIATE CAUSE: <i>Hypertensive Heart Disease</i> | | <i>3 years</i> | |
| (B) ANTECEDENT CAUSE (S): <i>Hypertension</i> | | | |
| (C) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Generalized arteriosclerosis</i> | | <i>3 yrs</i> | |
| 19A. DATE OF OPERATION: <i>none</i> | 19B. MAJOR FINDINGS OF OPERATION: <i>none</i> | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE (Home, farm, factory, street, office bldg., etc.) <i>Home</i> | 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? <i>no</i> | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: <i>no</i> | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> <i>at work</i> | 21F. HOW DID INJURY OCCUR? <i>no</i> | |
| 22. I hereby certify that I attended the deceased from <i>April 1955</i> , to <i>2-15-1956</i> , that I last saw the deceased alive on <i>2/15</i> , 1956, and that death occurred at <i>8:55</i> A.M. from the causes and on the date stated above. | | | |
| SIGNATURE <i>William S. Winter</i> M.D. | | DATE SIGNED <i>7/16/56</i> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | DATE THEREOF <i>2/18/56</i> | NAME OF CEMETERY OR CREMATORY <i>Bridgeville</i> | LOCATION (City, town, or county) (State) <i>Bridgeville Del.</i> |
| DATE REC'D BY LOCAL REGISTRAR <i>2/16/56</i> | REGISTRAR'S SIGNATURE <i>H. H. Neer</i> | 24. FUNERAL DIRECTOR ADDRESS <i>James B. Bodwell, Easton, Md.</i> | |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct ☒ is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 23 1956

THOMAS V. S.

1

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 104

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

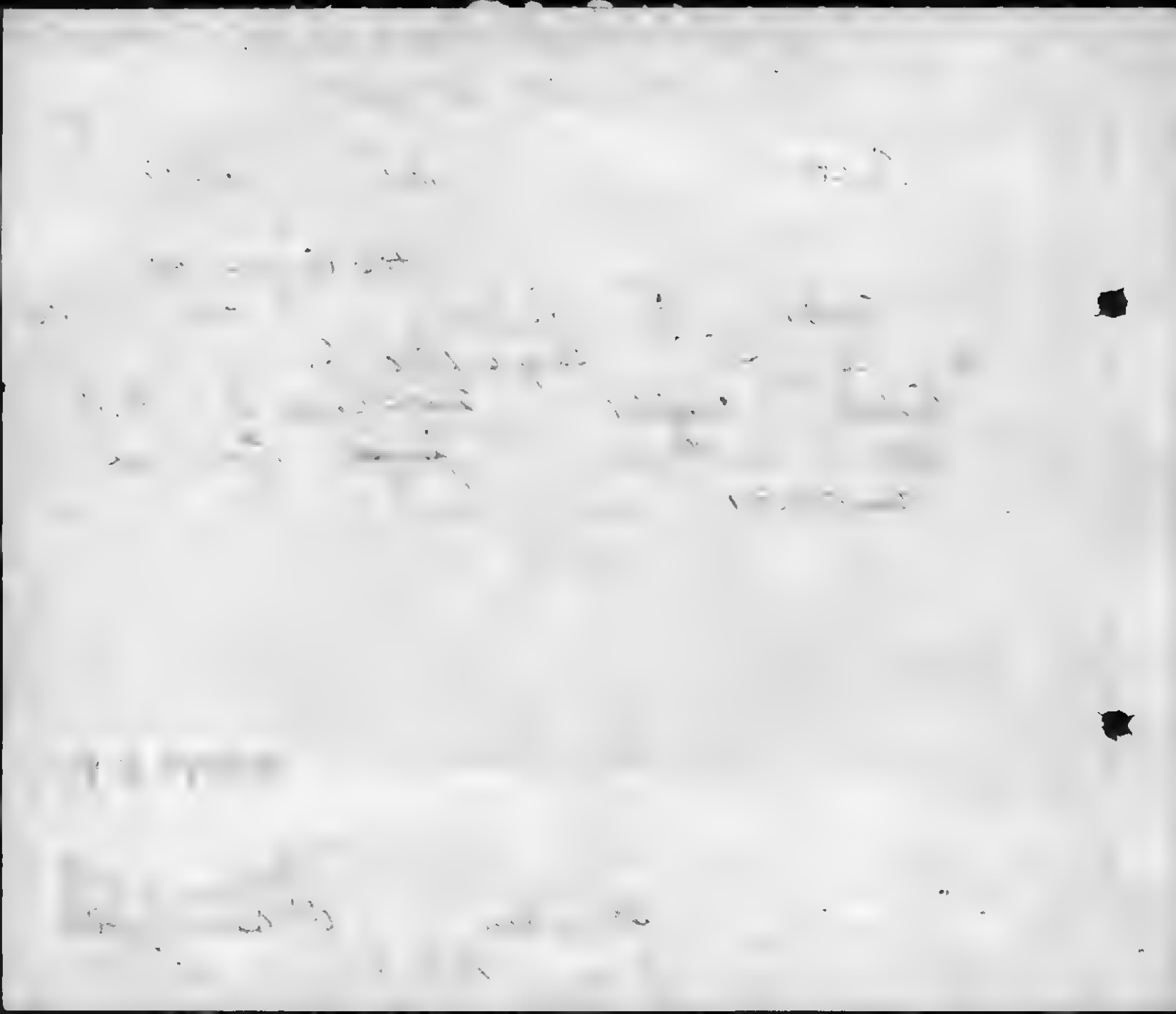
02178

2179 CERTIFICATE OF DEATH

Item 2, File 92 2-16-56 e

Reg. Dist. No. 290

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH | | 2. USUAL RESIDENCE (HOME) OF DECEASED | |
| COUNTY <i>Talbot</i> | MARYLAND | STATE <i> Md </i> | COUNTY <i>Talbot</i> |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Easton</i> | LENGTH OF STAY (In this place) <i>Life</i> | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Easton</i> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | STREET ADDRESS (If rural give location) <i>406 August St.</i> | |
| 3. NAME OF DECEASED (Type or Print) | | 4. DATE OF DEATH | |
| <i>Michael C. Sandelburg</i> | | <i>Feb. 7 1956</i> | |
| 5. SEX <i>M</i> | 6. COLOR OR RACE <i>W.</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH <i>Aug 16, 1890</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerk</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Hospital</i> | 9. AGE last birthday <i>65</i> yrs. |
| 11. BIRTHPLACE (State or foreign country) <i>Talbot County, Md</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i> | |
| 13. FATHER'S NAME <i>John J. Sandelburg</i> | | 14. MOTHER'S MAIDEN NAME <i>Josephine Burrage</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>World War I</i> | | 16. SOCIAL SECURITY NO. <i>216-03-7538</i> | |
| 17. MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | <i>6 mos.</i> | |
| IMMEDIATE CAUSE (A) <i>CARCINOMA of STOMACH</i> | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19a. DATE OF OPERATION <i>SEPT. 6, 1955</i> | 19b. MAJOR FINDINGS OF OPERATION <i>CARCINOMA of STOMACH</i> | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.) | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 21f. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from <i>Sept. 1955</i> to <i>Feb. 7, 1956</i> , that I last saw the deceased alive on <i>Feb. 7, 1956</i> , and that death occurred at <i>4:25 P.M.</i> from the causes and on the date stated above. | | | |
| SIGNATURE <i>Donald A. Bartley</i> | | ADDRESS (Street, city, town, state) <i>9 N. Harmon St. Easton, Md</i> | |
| DATE <i>2-9-56</i> | | DATE SIGNED <i>2-7-56</i> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | DATE THEREOF <i>2-9-56</i> | NAME OF CEMETERY OR CREMATORY <i>Spring Hill</i> | LOCATION (City, town, or county) (State) <i>Easton Md</i> |
| 24. REC'D BY REGISTRAR DATE <i>2/9/56</i> | REGISTRAR'S SIGNATURE <i>N.A. Neerius</i> | 25. FUNERAL DIRECTOR'S SIGNATURE <i>William E. Black</i> | |



2180 CERTIFICATE OF DEATH

Reg. Dist. No. 290

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

| | | | | | | | |
|--|--------------------------------|---|---------------------------------------|--|-----------------------------|--|--|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED. | | | |
| COUNTY <u>TALBOT</u> | | MARYLAND | | STATE <u>MARYLAND</u> COUNTY <u>TALBOT</u> | | | |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Easton</u> | | LENGTH OF STAY (in this place) <u>4 days</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Newitt</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hosp.</u> | | | | STREET ADDRESS (If rural give location) | | | |
| 3. NAME OF DECEASED: (First) <u>Estelle</u> (Middle) <u>Shores</u> (Last) <u>Shores</u> | | | | 4. DATE (Month) (Day) (Year) OF DEATH: <u>2</u> <u>2</u> <u>1956</u> | | | |
| 5. SEX: <u>F</u> | 6. COLOR OR RACE: <u>White</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u> | 8. DATE OF BIRTH: <u>July 11-1887</u> | 9. AGE last birthday <u>68</u> yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u> | | | 10B. KIND OF BUSINESS OR INDUSTRY: | 11. BIRTHPLACE (State or foreign country): <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME: <u>Mr. Edwin T. Fisher</u> | | | | 14. MOTHER'S MAIDEN NAME: <u>Frances Hill</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS: <u>Mr. Maurice Shores (Husband)</u> | |
| 15. MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| IMMEDIATE CAUSE (A) <u>Cerebral Capillary Thrombosis</u> | | | | | | <u>26 hrs.</u> | |
| ANTECEDENT CAUSE (B) <u>Diabetes Mellitus</u> | | | | | | <u>2 yr.</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Hypertension Cardiovascular</u> | | | | | | <u>4 yr.</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19A. DATE OF OPERATION: | | | | 19B. MAJOR FINDINGS OF OPERATION | | | |
| | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | | | 21E. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| 22. I hereby certify that I attended the deceased from <u>29 Jan.</u> , 1956, to <u>2 Feb.</u> , 1956, that I last saw the deceased alive on <u>2 Feb.</u> , 1956, and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>E. Anne Wirth</u> | | | | ADDRESS <u>51 St. Michaels Md.</u> | | DATE SIGNED <u>2-7-56</u> | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>2-4-56</u> | | NAME OF CEMETERY OR CREMATORY <u>Oliver</u> | | LOCATION (City, town, or county) (State) <u>St. Michael Md</u> | |
| DATE REC'D BY LOCAL REGISTRAR <u>2-3-56</u> | | REGISTRAR'S SIGNATURE <u>H. H. Neer</u> | | 24. FUNERAL DIRECTOR <u>Norman H. Marchant</u> | | ADDRESS | |

MARGIN RESERVED FOR BINDING

LIBRARY U. S.

RECEIVED

2181

CERTIFICATE OF DEATH

Reg. Dist. No. 290...

| | | | | | | | |
|--|-------------------------------|--|--|---|---|---|--|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>Talbot</u> | | MARYLAND | | STATE <u>Md</u> | | COUNTY <u>Caroline</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Easton</u> | | LENGTH OF STAY (in this place) <u>3 days</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Preston</u> <u>05x-2</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hospital</u> | | | | STREET ADDRESS (If rural give location) | | | |
| 3. NAME OF DECEASED: (Type or Print) <u>Thomas Foreman Smith</u> | | | | 4. DATE (Month) (Day) (Year) OF DEATH: <u>Feb. 17, 1956</u> | | | |
| 5. SEX: <u>m</u> | 6. COLOR OR RACE: <u>w</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>nm</u> | 8. DATE OF BIRTH: <u>August 9, 1886</u> | 9. AGE last birthday <u>69</u> yrs. | 10. IF UNDER 1 YEAR Months Days Hours Min. | 11. IF UNDER 24 HRS. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): | | 10B. KIND OF BUSINESS OR INDUSTRY: <u>nm</u> | | 11. BIRTHPLACE (State or foreign country): <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME: <u>George W Smith</u> | | | | 14. MOTHER'S MAIDEN NAME: <u>Jane Robertson</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>7</u> | | | |
| 17. INFORMANT & ADDRESS: <u>Mrs Roland Thomas (Sister)</u> | | | | 18. MEDICAL CERTIFICATION | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| 527.1 IMMEDIATE CAUSE | | | | (A) <u>Emphysema</u> | | | |
| ANTECEDENT CAUSE (S) | | | | (B) <u>High blood pressure</u> | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. | | | | (C) <u>Myocardial infarction</u> | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19A. DATE OF OPERATION: | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? | | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from , 19....., to , 19....., that I last saw the deceased alive on , 19....., and that death occurred at M, from the causes and on the date stated above. SIGNATURE <u>Robert J. Carter</u> M. D. <u>Carter</u> DATE SIGNED <u>2-18-56</u> | | | | | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF <u>Feb 20</u> | | NAME OF CEMETERY OR CREMATORY <u>Greenwood</u> | | LOCATION (City, town, or county) (State) <u>Easton, Md</u> | |
| DATE REC'D BY LOCAL REGISTRAR <u>2-18-56</u> | | REGISTRAR'S SIGNATURE <u>H. D. Newer</u> | | FEDERAL DIRECTOR <u>A. H. H. Moore</u> | | ADDRESS <u>Staw.</u> | |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 27 19

RECEIVED

2182 CERTIFICATE OF DEATH

Reg. Dist. No. 290

| | | | | | | | |
|--|-------------------|---|------------------------|--|-----------------|--|------------|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <i>Talbot</i> | | MARYLAND | | STATE <i>Maryland</i> COUNTY <i>Caroline</i> | | | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (In this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN | | | |
| TOWN <i>E. Aston</i> | | <i>10 days</i> | | TOWN <i>Greensboro</i> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Memorial Hospital</i> | | | | STREET ADDRESS (If rural give location) | | | |
| 3. NAME OF DECEASED: (First) (Middle) (Last) | | | | 4. DATE (Month) (Day) (Year) | | | |
| <i>Charles Henry Sparks</i> | | | | <i>2 3 1956</i> | | | |
| 5. SEX: | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): | 8. DATE OF BIRTH: | 9. AGE last birthday | IF UNDER 1 YEAR | IF UNDER 24 HRS. | |
| <i>M</i> | <i>White</i> | <i>Married</i> | <i>August 29, 1892</i> | <i>63</i> yrs. | Months | Days | Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10B. KIND OF BUSINESS OR INDUSTRY: | | 11. BIRTHPLACE (State or foreign country): | |
| <i>Steel Constructor</i> | | | | <i>Iron Works</i> | | <i>Maryland</i> | |
| 13. FATHER'S NAME: | | | | 14. MOTHER'S MAIDEN NAME: | | | |
| <i>Mr. Henry Sparks</i> | | | | <i>Sarah Anderson</i> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS: | |
| | | | | | | <i>Mrs. Grace Sparks (wife)</i> | |
| 18. MEDICAL CERTIFICATION | | | | | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| IMMEDIATE CAUSE | | | | (A) DUE TO | | | |
| <i>Myocardial Infarct</i> | | | | | | | |
| ANTECEDENT CAUSE (S) | | | | (B) DUE TO | | | |
| <i>Coronary thrombosis</i> | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. | | | | (C) DUE TO | | | |
| <i>moribund</i> | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19A. DATE OF OPERATION: | | | | 19B. MAJOR FINDINGS OF OPERATION | | | |
| | | | | | | | |
| 20. AUTOPSY? | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21C. WHERE DID (City or town) (County) (State) | |
| | | | | | | INJURY OCCUR? | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from <i>Jan 24, 1956</i> to <i>Feb 3, 1956</i> that I last saw the deceased alive on <i>Feb 3, 1956</i> and that death occurred at <i>10:20 P.M.</i> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <i>Dr. H. J. ...</i> | | | | ADDRESS <i>Canton</i> | | DATE SIGNED <i>Feb. 4, 1956</i> | |
| M. D. | | | | | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <i>buried</i> | | <i>2/6/56</i> | | <i>Greensboro</i> | | <i>Greensboro Md.</i> | |
| DATE REC'D BY LOCAL REGISTRAR | | REGISTRAR'S SIGNATURE | | 24. FUNERAL DIRECTOR | | ADDRESS | |
| <i>3-4-56</i> | | <i>H. A. ...</i> | | <i>J. E. Boulaire</i> | | <i>Greensboro Md.</i> | |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

RECEIVED

2183 CERTIFICATE OF DEATH

Reg. Dist. No. 290

| | | | | | | | |
|---|----------------------------------|--|-----------------------------------|---|-----------------------------|--|--|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <u>TALBOT</u> | | MARYLAND | | STATE <u>Maryland</u> COUNTY <u>TALBOT</u> | | | |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>EASTON</u> | | LENGTH OF STAY (in this place) <u>28 hrs</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>EASTON</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>EASTON Memorial</u> | | | | STREET ADDRESS (If rural give location) <u>313 SOUTH LANE</u> | | | |
| 3. NAME OF DECEASED: (First) (Middle) (Last) <u>William H. STATEN</u> | | | | 4. DATE (Month) (Day) (Year) OF DEATH: <u>2</u> <u>14</u> <u>1936</u> | | | |
| 5. SEX: <u>M</u> | 6. COLOR OR RACE: <u>COLORED</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>WIDOWED</u> | 8. DATE OF BIRTH: <u>1/6/1872</u> | 9. AGE last birthday <u>84</u> yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Laborer</u> | | | | 10B. KIND OF BUSINESS OR INDUSTRY: | | 11. BIRTHPLACE (State or foreign country): <u>MARYLAND</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>UNITED STATES</u> | | | | | | | |
| 13. FATHER'S NAME: <u>Henry STATEN</u> | | | | 14. MOTHER'S MAIDEN NAME: <u>Caroline Gibson</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS: <u>Anno Gibson (daughter)</u> | |
| 18. MEDICAL CERTIFICATION | | | | | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| IMMEDIATE CAUSE <u>420.0</u> | | | | (A) <u>Uremia</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>7-10 dgs</u> | |
| ANTECEDENT CAUSE (\$) | | | | (B) <u>Cardiac Decompensation</u> | | <u>2 wks</u> | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. | | | | (C) <u>Hypertensive Arteriosclerotic Heart Disease</u> | | <u>20 yrs</u> | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Osteoarthritis</u> | | | | | | <u>25 yrs</u> | |
| 19A. DATE OF OPERATION: | | 19B. MAJOR FINDINGS OF OPERATION | | | | | |
| | | | | | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21C. WHERE DID (City or town) INJURY OCCUR? (County) (State) | | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21F. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from <u>8/2</u> , 19 <u>36</u> , to <u>2/14</u> , 19 <u>36</u> , that I last saw the deceased alive on <u>2/4</u> , 19 <u>36</u> , and that death occurred at <u>11</u> <u>PM</u> , from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>James B. Reiman</u> | | M. D. <u>Preston M. G.</u> | | DATE SIGNED <u>2/15/36</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>2/17/36</u> | | NAME OF CEMETERY OR CREMATORY <u>Mt. Pleasant</u> | | LOCATION (City, town, or county) (State) <u>Preston Md</u> | |
| DATE REC'D BY LOCAL REGISTRAR <u>2/18/36</u> | | REGISTRAR'S SIGNATURE <u>N. H. Neekes</u> | | 24. FUNERAL DIRECTOR <u>James B. Radwell</u> | | ADDRESS <u>Easton, Md.</u> | |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 23 1956

BUREAU V. S.

2184 CERTIFICATE OF DEATH

Reg. Dist. No. 290...

| | | | | | | | |
|---|----------------------------|--|---------------------------------------|--|------------------------------|---|--|
| 1. PLACE OF DEATH: | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | | | |
| COUNTY <i>Talbot</i> | | MARYLAND | | STATE <i>Maryland</i> | | COUNTY <i>Talbot</i> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (In this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN <i>Easton</i> | | 14 days | | TOWN <i>Easton</i> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Memorial Hospital</i> | | | | STREET ADDRESS (If rural give location) | | | |
| 3. NAME OF DECEASED: (First) (Middle) (Last) | | | | 4. DATE (Month) (Day) (Year) OF DEATH: 2 11 1956 | | | |
| Nannie Irene Stevens | | | | | | | |
| 5. SEX: <i>Female</i> | 6. COLOR OR RACE: <i>W</i> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>single</i> | 8. DATE OF BIRTH: <i>Jan. 21 1867</i> | 9. AGE last birthday: <i>89</i> yrs. | IF UNDER 1 YEAR: Months Days | IF UNDER 24 HRS.: Hours Min. | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i> | | 10B. KIND OF BUSINESS OR INDUSTRY <i>Teacher</i> | | 11. BIRTHPLACE (State or foreign country): <i>Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME: <i>Nicholas Bourde Stevens</i> | | | | 14. MOTHER'S MAIDEN NAME: <i>Mario Elizabeth Benson</i> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | | |
| | | | | 17. INFORMANT & ADDRESS: <i>Mrs. Irene S. Hardin (Niece)</i> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| IMMEDIATE CAUSE (A) <i>Cerebrovascular Thrombosis</i> | | | | 3 months | | | |
| ANTECEDENT CAUSE (B) <i>Arteriosclerosis - generalized</i> | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. | | | | | | | |
| (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19A. DATE OF OPERATION: | | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? | | | |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21F. HOW DID INJURY OCCUR? | | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from <i>June, 1944</i> to <i>Feb. 11, 1956</i> that I last saw the deceased alive on <i>Feb. 11, 1956</i> , and that death occurred at <i>1:25 AM</i> , from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <i>M. V. Palmer</i> | | M. D. <i>Carlson, Md.</i> | | DATE SIGNED <i>2/17/56</i> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | DATE THEREOF <i>2/13/56</i> | | NAME OF CEMETERY OR CREMATORY <i>Pifford</i> | | LOCATION (City, town, or county) (State) <i>Pifford Talbot Md</i> | |
| DATE REC'D BY LOCAL REGISTRAR <i>2/2/56</i> | | REGISTRAR'S SIGNATURE <i>M. A. Newries</i> | | 24. FUNERAL DIRECTOR <i>M. E. Newnam & Son</i> | | ADDRESS | |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DECEMBER 6, 1955

RECEIVED

DECEMBER 6, 1955

2192 CERTIFICATE OF DEATH

Reg. Dist. No. 290

| | | | | | | | |
|--|------------------|--|-----------------------------------|---|---|--|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>TALBOT</u> | | MARYLAND | | STATE <u>MD.</u> | | COUNTY <u>TALBOT</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) | | LENGTH OF STAY (in this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) | | | |
| TOWN <u>TRAPPE</u> | | <u>Entire life</u> | | TOWN <u>TRAPPE</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) | | | |
| 3. NAME OF DECEASED (Type or Print) | | | | 4. DATE OF DEATH | | | |
| (First) <u>ELLEN</u> (Middle) <u>LEE</u> (Last) <u>SULLIVAN</u> | | | | (Month) <u>FEB.</u> (Day) <u>21</u> (Year) <u>1956</u> | | | |
| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR | | IF UNDER 24 HRS |
| <u>FEMALE</u> | <u>WHITE</u> | <u>MARRIED</u> | <u>APR. 4, 1914</u> | <u>41</u> yrs. | Months | Days | Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY |
| <u>HOUSEWIFE</u> | | | | | <u>MARYLAND</u> | | <u>U.S.</u> |
| 13. FATHER'S NAME | | | | 14. MOTHER'S MAIDEN NAME | | | |
| <u>OLIVER L. CORKRAN</u> | | | | <u>NELLIE GRIFFITH</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS | | | |
| | | <u>None</u> | | <u>MR DOUGLAS SULLIVAN-TRAPPE MD.</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (A) <u>Uremia</u> | | | | | | | <u>6 mos.</u> |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic nephritis</u> | | | | | | | <u>Years</u> |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Hypertension</u> | | | | | | | <u>Years</u> |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) | | (County) (State) | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | | 21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>5-8-</u> , 19 <u>55</u> , to <u>2-21-</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2-21-56</u> , 19 <u>56</u> , and that death occurred at <u>2:40 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Ronald A. Bartley</u> | | | | DATE SIGNED <u>2-21-56</u> | | | |
| M.D. <u>9 N. Hanson St. Easton, Md.</u> | | | | ADDRESS (Street, city, town, state) | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) | | DATE THEREOF | | NAME OF CEMETERY OR CREMATORY | | LOCATION (City, town, or county) (State) | |
| <u>BURIAL</u> | | | | <u>SPRING HILL CEMETERY</u> | | <u>EASTON TALBOT MD.</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | | ADDRESS | |
| DATE <u>2/22/56</u> | | <u>N. S. Neer</u> | | <u>Maurice E. Newnam</u> | | <u>Easton Md.</u> | |

INSTRUCTIONS

TO ATTENDING PHYSICIAN: The law requires that the death certificate be filed with the registrar within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1944

EB

1944

2185 CERTIFICATE OF DEATH

Reg. Dist. No. 290

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH: | | 2. USUAL RESIDENCE (HOME) OF DECEASED: | |
| COUNTY <u>Talbot</u> | MARYLAND | STATE <u>Maryland</u> | COUNTY <u>Talbot</u> |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Easton</u> | LENGTH OF STAY (in this place) <u>2 da.</u> | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Easton</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memoria Hospital</u> | | STREET ADDRESS (If rural give location) | |
| 3. NAME OF DECEASED: (Type or Print) <u>Baby Boy Thomas</u> | | 4. DATE (Month) (Day) (Year) OF DEATH <u>2 9 1956</u> | |
| 5. SEX: <u>M</u> | 6. COLOR OR RACE: <u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): | 8. DATE OF BIRTH: <u>2-7-56</u> |
| 9. AGE last birthday <u>2</u> yrs. <u>2</u> months <u>2</u> days | | 10. IF UNDER 1 YEAR: <u>2</u> Months <u>2</u> Days | |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): | | 10B. KIND OF BUSINESS OR INDUSTRY: | 11. BIRTHPLACE (State or foreign country): <u>md.</u> |
| 13. FATHER'S NAME: <u>William E Thomas</u> | | 14. MOTHER'S MAIDEN NAME: <u>Wadney Minster</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | | 17. INFORMANT & ADDRESS: <u>Audrey Thomas (mother)</u> | |
| 15. MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | |
| IMMEDIATE CAUSE (A) | <u>Intracranial Hemorrhage</u> | | |
| ANTECEDENT CAUSE (B) | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | |
| 19A. DATE OF OPERATION: | 19B. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21C. WHERE DID (City or town) (County) (State) | 21F. HOW DID INJURY OCCUR? |
| 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY | 21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | |
| 22. I hereby certify that I attended the deceased from <u>2-7-</u> , 19 <u>56</u> , to <u>2-9-</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Feb. 9</u> , 19 <u>56</u> , and that death occurred at <u>8:30</u> A.M. from the causes and on the date stated above. | | | |
| SIGNATURE <u>Donald F. Bartley</u> | | DATE SIGNED <u>2-9-56</u> | |
| M. D. <u>Easton, Md.</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (Specify): <u>Cremation</u> | DATE THEREOF <u>2/10/56</u> | NAME OF CEMETERY OR CREMATORY <u>Memorial Hospital</u> | LOCATION (City, town, or county) (State) <u>Memorial Hospital</u> |
| DATE REC'D BY LOCAL REGISTRAR <u>2/10/56</u> | REGISTRAR'S SIGNATURE <u>H. A. Neer</u> | FUNERAL DIRECTOR <u>Memorial Hospital</u> | ADDRESS <u>Easton, Md.</u> |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 23 1956

BUREAU V. S.

2193

02186

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No.

1. PLACE OF DEATH:

COUNTY **TALBOT** MARYLAND
 CITY (If outside corporate limits, write RURAL OR and give nearest town) **NR EASTON**
 TOWN **NR EASTON** LENGTH OF STAY (In this place)

HOSPITAL OR
 INSTITUTION OR
 STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE **MARYLAND** COUNTY **CAROLINE**
 CITY (If outside corporate limits write RURAL and give nearest town) **FEDERALSBURG**
 TOWN **FEDERALSBURG**

STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (First) **JOHN**
 (Type or Print)

(Middle) **IRELAND**

(Last) **WELLS**

4. DATE OF DEATH (Month) **2** (Day) **8** (Year) **19 56**

5. SEX: **male**

6. COLOR OR RACE: **white**

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): **married**

8. DATE OF BIRTH: **12/22/06**

9. AGE last birthday: **49** yrs. IF UNDER 1 YEAR IF UNDER 24 HRS.
 Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): **Truck Driver**

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): **N. J.**

12. CITIZEN OF WHAT COUNTRY? **U.S.**

13. FATHER'S NAME:

John I. Wells

14. MOTHER'S MAIDEN NAME:

Nettie Bergman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) **Yes** **World War II**

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause

(a) **Carbon monoxide poisoning**

DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) **sleeping in cab of parked tractor-trailer**

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

INTERVAL BETWEEN ONSET AND DEATH

20. AUTOPSY? Yes ☒ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) **nr Easton Talbot Md**

21c. (City or town)

(County)

(State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY **2 8 56 e 2AM**

21e. INJURY OCCURRED While at / Not while work ☒ at work ☐

21f. HOW DID INJURY OCCUR?

parked to sleep-asphyxiated

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

Louis M. Mott

Easton, Md. M. D.

CHIEF MEDICAL EXAMINER ☐ DATE SIGNED **12-10-56**
 DEPUTY MEDICAL EXAMINER ☒
 ASSISTANT MEDICAL EXAM. ☐

23. BURIAL, CREMATION, REMOVAL (Specify): **Burial**

DATE THEREOF **2/11/56**

NAME OF CEMETERY OR CREMATORY **East New Market**

LOCATION (City, town, or county) **East New Market, Md.**

(State)

DATE REC'D BY LOCAL REG. **2/9/56**

REGISTRAR'S SIGNATURE **N. H. Nevius**

24. FUNERAL DIRECTOR **J. J. Frampton**

ADDRESS

Federalsburg Md.

MARGIN RESERVED FOR BANDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Two for One: Film 92 2-15-56 et

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02187

2194

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|---------------------------------------|---|---|---|---------------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>talbot</u> | | MARYLAND | | STATE <u>Maryland</u> | | COUNTY <u>talbot</u> | |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Easton</u> | | LENGTH OF STAY (in this place) <u>Life</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Easton</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Route 3, Box 128</u> | | | | STREET ADDRESS (If rural give location) <u>Route 3 Box 128</u> | | | |
| 3. NAME OF DECEASED (Type or Print) <u>Hazel</u> (First) <u>Wilkins</u> (Middle) (Last) | | | | 4. DATE OF DEATH (Month) <u>2</u> (Day) <u>14</u> (Year) <u>1956</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Col</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u> | 8. DATE OF BIRTH <u>5/29/1893</u> | 9. AGE last birthday <u>62</u> yrs. | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Andrew Wilkins</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Elizabeth Johnson</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) | | 16. SOCIAL SECURITY NO. <u>218-24-4232</u> | | 17. INFORMANT & ADDRESS <u>Mrs Fannie Wilkins</u> | | | |
| 18. MEDICAL CERTIFICATION | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | | |
| IMMEDIATE CAUSE (A) <u>Cerebral Vascular Hemorrhage</u> | | | | <u>Instant.</u> | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive Cardiovascular Disease</u> | | | | <u>Yrs.</u> | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Chronic Glomerulonephritis</u> | | | | <u>Yrs.</u> | | | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 2D. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>6/20</u> , 19 <u>55</u> , to <u>2/14</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2/13</u> , 19 <u>56</u> , and that death occurred at <u>5 P.</u> M., from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Shepherd</u> M.D. | | | | ADDRESS (Street, city, town, state) <u>Easton</u> | | DATE SIGNED <u>2/18/56</u> | |
| 23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | DATE THEREOF <u>2/17/56</u> | | NAME OF CEMETERY OR CREMATORY <u>Cordova Cemetery</u> | | LOCATION (City, town, or county) (State) <u>Cordova, Md.</u> | |
| 24. REC'D BY REGISTRAR DATE <u>FEB 27 1956</u> | | REGISTRAR'S SIGNATURE <u>N. H. Newis</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Dashiell</u> ADDRESS <u>Easton, Md.</u> | | | |

CERTIFICATE OF DEATH

REG. GEN. 12

NAME OF DECEASED

AGE

SEX

RACE

DATE OF BIRTH

DATE OF DEATH

PLACE OF BIRTH

PLACE OF DEATH

CAUSE OF DEATH

DIAGNOSIS

DATE OF EXAMINATION

SIGNATURE OF PHYSICIAN

SIGNATURE OF REGISTRAR

DATE OF REGISTRATION

PLACE OF REGISTRATION

NAME OF REGISTRAR

DATE OF REGISTRATION

PLACE OF REGISTRATION

NAME OF REGISTRAR

DATE OF REGISTRATION

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DATE OF REGISTRATION

PLACE OF REGISTRATION

NAME OF REGISTRAR

DATE OF REGISTRATION

PLACE OF REGISTRATION

BUREAU V. S.

FEB 27 1933

RECEIVED